Terminology in cervical cytology/cervical histopathology

In two recent publications in *Genitourinary Medicine*, there has been reference to the results of cervical cytological examination by grading of cervical intra-epithelial neoplasia. (CIN)[1 2]

It may be that confusion arises because of the perception that CIN grading accurately reflects the cervical cytology grading. It is well recognised that variation occurs between these two wholly different investigations.[3]

A survey for the British Society for Colposcopy and Cervical Pathology in 1990 suggested that some 3,500 new genitourinary medicine patients were examined colposcopically per annum.[4] This represents some 5% of the total colposcopic workload and an increase is anticipated.

Confusion between cytological and histological terminology appeared in the Journal in the Genital Neoplasia section of the excellent editorial review of the 7th International AIDS Conference.[1] *"A study from New York looked at the CD4 counts and cervical smears of 44 HIV positive women. The prevalence of CIN was higher in those with CD4 counts below 0·2 × 10°/1."* [1]

Whilst this may be merely an implied discrepancy, (as it is not stated whether or not this group were diagnosed by biopsy) a further example is provided by Mali *et al.* *"Papanicolaou smear is a well established screening technique available for the diagnosis of cervical cancer and intraepithelial neoplasia."* [2]

In order to ensure effective collaboration between colposcopists within different disciplines; (and to ensure that patient confidence is maintained) it appears vital that the results of cervical cytology investigations are described as showing features of cytological significance. That is, features of dyskaryosis covering the recognised range of severity.

If the patient is subsequently examined colposcopically and has a diagnosis based on colpo-biopsy then the features relating to histological diagnosis will be described using the cervical intra-epithelial neoplasia (CIN) grading. To describe cervical cytology studies as producing diagnostic information on CINI-III is misleading.

Perhaps it is appropriate to ask for a greater awareness of the need to use valid diagnostic terminology in a disease process which is as yet incompletely understood. The importance of this is enhanced by the Report of the National Audit Office[5] where it is recommended that Health Authorities review efficiency and effectiveness of cervical cytology programmes. (Part of this report refers to monitoring the effectiveness of the programme and recommends that Health Authorities undertake periodic reviews ... *"biopsy results compared to smear test results"*.) Surely the use of accurate terminology is fundamental to achieving this objective.

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2 Mali B, Joshi JV, Bhave GG, Wagle UD. Cervical Cytology in Prostitutes in Bombay (India). *Genitourin Med* 1992;**68**:62–3.
3 Giles JA, Deery A, Crow J, Walker P. The accuracy of repeat cytology in women with mildly dyskaryotic smears. *Br J Obst & Gynaecol* 1989;**96**:1067–70.
4 Williams O, Bodha M, Hicks DA, Alawattegama AB. Survey of colposcopy services provided by genitourinary medicine in England and Wales. Presented at the Annual Scientific Meeting of the BSCCP, Sheffield, UK 29–31 March 1990.
5 National Audit Office. Cervical and Breast Screening in England. 11 February 1992. p19 2.60. House of Commons Paper, London HMSO.

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Treatment failure using double dose ciprofloxacin in a case of highly resistant gonorrhoea

Aminoquinolones are currently the drugs of first choice for treatment of gonorrhoea in many genitourinary medicine (GUM) clincs in the UK. The early reports of success with single dose (250 mg) treatment were encouraging but Jephcott *et al*[1] advised "caution in the use of single dose ciprofloxacin in the treatment of uncomplicated genital gonorrhoea", having found *in vitro* resistance with MICs up to 0·1 mg/l.

Bearing this in mind, when a 23 year old sales executive attended our clinic in April 1990 with gonorrhoea, contracted in Bangkok one week previously, he was treated with 500 mg ciprofloxacin (twice the usual dose).

When he returned a few days later he still had gonorrhoea (on Gram stain and subsequently grown in culture). The original isolate was reported from another laboratory as sensitive to ciprofloxacin although it was resistant to penicillin (beta lactamase producer). He was therefore retreated with 500 mg ciprofloxacin and blood was taken at 1½ hours for a ciprofloxacin level. This was later found to be well within the therapeutic range.

This time, samples of the discharge were also sent to the University Department of Microbiology and the following sensitivities were reported; penicillin resistant (beta lactamase producer), tetracycline moderately resistant, spectinomycin sensitive, ciprofloxacin resistant—the MIC was 0·6 mg/l (200 times greater than the usual MIC).

When seen a few days later he still had gonorrhoea which finally resolved on treatment with spectinomycin 2 mg I/M—confirmed at follow up by negative microscopy and culture.

A study reported at the MSSVD meeting in Heidelberg[2] found two out of 329 strains of *Neisseria gonorrhoeae* resistant to ciprofloxacin MIC = 0·25 mg/l.

Of 896 consecutive isolates tested by Ison *et al*[3] only three isolates showed an MIC > 0·12 mg/l; actual treatment failure was not reported.

However, the case described above is a clearly documented case of *treatment failure* (not simply *in vitro* resistance) despite using a more than adequate dose of an aminoquinolone. The *in vitro* resistance was paralleled by